Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
NABIL BISHARA, MD

Respondent Name
CITY OF SAN ANTONIO

MFDR Tracking Number
M4-13-2369-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 16, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The enclosed claim was reduced in error. This claim was for a Division ordered Designated Doctor Exam. We billed a total of $2,350.00 for this claim but were paid $1,050.00. The explanation given on the EOB justifying the denial states: *WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT,* however, this is incorrect. The reduction of parts of this claim is in violation of the rules of the Texas Department of Insurance Division of Workers' Compensation as this services was ordered on the DWC-32."

Amount in Dispute: $100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… The explanation of benefits should have reflected an allowance of $500.00 for code 99456W6RE with the reduction code W1JA that states:

Workers Compensation State Fee Schedule Adjustment Designated doctor tiered reimbursement method for more than one non-MMI/IR exams under the same order 1st exam = 500.00; 2nd exam= $250.00; subsequent exam =$125.00."

Response Submitted by: Argus Services Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 08, 2012	CPT Code 99456-W6-RE	$100.00	$ 100.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the medical fee guidelines for workers compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1J – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT ***OLD LAW*

REIMBURSEMENT PER 1996 MEDICAL FEE GUIDELINE

- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY

Issues

1. Did the requestor receive reimbursement according to 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (i) and (k) states "The following shall apply to Designated Doctor Examinations." (k) The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."

   Review of submitted documentation provided the requestor billed for one unit of CPT Code 99456-W6-RE. Reimbursement shall be $500 in accordance with 28 Texas Administrative Code §134.204 (k).
2. The respondent issued payment in the amount of $250.00. Based upon the documentation submitted and the *Table of Disputed Services*, additional reimbursement in the amount of $100.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $ 100.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $100.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	4/11/14 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.